UPMC HEALTH PLAN

Eylea and Lucentis
Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ☐ **Brand** ☐ **Generic**	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	☐ **Yes** ☐ **No**
Diagnosis:		**Date of diagnosis:**	

Please indicate place of administration: ☐ **Physician Office** ☐ **Hospital/facility**

Please provide facility/provider name and address:

Please indicate how medication will be billed:
☐ Billed directly by **the provider via JCODE**
Provider JCODE:_____
☐ Billed by **a pharmacy and delivered to the provider**
☐ Billed by **a pharmacy and delivered to the patient**

Medical History

For Lucentis (ranibizumab):

Please indicate diagnosis:

☐ Neovascular (wet) **age-related macular degeneration**
☐ **Macular edema following retinal vein occlusion**
☐ Diabetic Macular Edema
☐ Other (please specify):_____

For Eylea (aflibercept):

Please indicate diagnosis:

☐ Neovascular (wet) **age-related macular degeneration**
☐ Other (please specify):_____
☐ **Macular edema following central retinal vein occlusion**

Does the member have an active ocular or periocular infection?
☐ **Yes**
☐ **No**

Does the member have active intraocular inflammation?
☐ **Yes**
☐ **No**

Is the provider a retinal specialist?
☐ **Yes**
☐ **No**

Please provide any additional information which should be considered in the space below: